IN THE MATTER OF:	THE MEDICAL ACT, C.C.S.M. c**.** M90
AND IN THE MATTER OF:	Dr. SONNY SUREJ DHALLA**,** a member of the College of Physicians and Surgeons of Manitoba
AND IN THE MATTER OF:	A Notice of Inquiry dated December 7, 2018

INQUIRY PANEL:

Dr. Alex Vajcner, Chairperson

Dr. Brent Anderson

Sandra Benavidez, Public Representative

REASONS FOR DECISION OF AN INQUIRY PANEL OF THE COLLEGE OF PHYSICIANS AND SURGEONS OF MANITOBA RE FINDINGS UNDER S.59.5 OF THE MEDICAL ACT

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REASONS FOR DECISION OF THE INQUIRY PANEL

INTRODUCTION

On September 11, 2019, a hearing was convened before an Inquiry Panel (the "Panel") of the College of Physicians and Surgeons of Manitoba (the "College"), for the purpose of conducting an inquiry pursuant to Part X of *The Medical Act, C.C.S.M. c. M90* (the "*Act")* into allegations against Dr. Sonny Surej Dhalla ("Dr. Dhalla") as set forth in a Notice of Inquiry dated December 7, 2018.

The Notice of Inquiry alleged that Dr. Dhalla had contravened Articles 1, 9, 10 and 27.6 of the Code of Conduct, Schedule G to By-Law 1 of the College, and/or had contravened Article 24.1 of By-Law 1 of the College and/or had displayed a lack of knowledge, skill and judgment in the practice of medicine and/or had been guilty of professional misconduct.

Specifically, in charge 1, the Notice of Inquiry alleged that between November 5 and 12, 2015, during the admission to hospital of a patient ("Patient Y"), when Dr. Dhalla was the admitting physician and the most responsible physician in his capacity as a consultant general surgeon, for treating and managing Patient Y for a gastric volvulus and subsequent complications, Dr. Dhalla:

(a) While performing an endoscopy procedure for Patient Y on November 9, 2015, failed to respond to Patient Y's abnormal vital signs. After the procedure, Dr. Dhalla failed to ensure that Patient Y was in stable condition prior to departing the operating room, rendering himself no longer immediately available to address any surgical complication that required urgent attention.

(b) After the surgical complication was identified and Patient Y was transferred to the Intensive Care Unit, Dr. Dhalla failed to address the surgical complications in a timely manner, including failing to appreciate and address a known perforation and evidence of ongoing ischemic changes.

(c) On November 12, when Patient Y required urgent surgical intervention, Dr. Dhalla failed to ensure continuity of care for Patient Y and/or to provide appropriate assistance when Dr. Dhalla declined to assist in circumstances where he remained responsible for Patient Y.

In addition, in charge 2, the Notice of Inquiry alleged that between November 5 and 12, 2015, Dr. Dhalla failed to adequately document his involvement in the care and management of Patient Y in the medical record.

The hearing convened before the Panel on September 11, 2019, in the presence of Dr. Dhalla and his counsel, and in the presence of counsel for the Investigation Committee of the College. Dr. Dhalla, through his counsel, admitted his membership in the College, acknowledged that the College had fulfilled all necessary procedural requirements, and that the Panel had been properly constituted and had jurisdiction over the matters at issue. Dr. Dhalla, through his counsel, also acknowledged service upon him of the Notice of Inquiry.

At the commencement of the hearing, counsel for the Investigation Committee of the College (the "Investigation Committee") made a motion pursuant to subsections 56(2) and 56(3) of *The Medical Act* for an Order of non-disclosure with respect to the name of Patient Y and the names of any family members of Patient Y referred to in the proceedings, or in any of the exhibits filed in the proceedings. Dr. Dhalla, through his counsel, consented to such an Order.

Counsel for the Investigation Committee also asked that a doctor whose evidence was expected to be important in the proceedings, be included within the Order of Non-Disclosure, or such doctor be referred to by a pseudonym. The evidence of that doctor was the subject of a separate preliminary motion made by the Investigation Committee, which motion will be more particularly described below. The basis of the Investigation Committee's request for that doctor to be included within the Order of Non-Disclosure, was a concern that during the submissions with respect to the separate preliminary motion, or during the balance of the proceedings, reference might be made to that doctor's personal health information.

The Panel being satisfied that the desirability of avoiding public disclosure of those names outweighed the desirability of the names being made public, granted the Order of non-disclosure with respect to Patient Y and any of Patient Y's family members who may be referred to in the proceedings, and with respect to the doctor whose evidence was the subject of the motion made by the Investigation Committee.

Dr. Dhalla waived the reading of the Notice of Inquiry and entered a plea of not guilty to charge 1, and a plea of guilty to charge 2 in the Notice of Inquiry.

THE INVESTIGATION COMMITTEE'S PRELIMINARY MOTION

The balance of the hearing on September 11, 2019 was devoted to the hearing of a motion brought by the Investigation Committee, requesting that the Panel accept the evidence of the doctor referred to above (hereinafter referred to as "Dr. X") by way of an Affidavit sworn by Dr. X on September 5, 2019, without having Dr. X testify at the hearing. The motion was strenuously opposed by Dr. Dhalla.

In November 2015, Dr. X had been a physician in the Intensive Care Unit (the "ICU") at the hospital where Patient Y was admitted. On November 9, 2015, Patient Y was admitted to the ICU. In the days thereafter, Dr. X observed Patient Y and was involved in his care. Dr. X also had numerous interactions with Dr. Dhalla. Dr. X made numerous chart entries regarding involvement with Patient Y.

By a letter dated September 8, 2017, Dr. X responded to inquiries from the College's Medical Consultant relating to the treatment of Patient Y while he was in hospital in November 2015. Thereafter, on October 29, 2018, Dr. X attended at the College's offices and was interviewed by representatives of the College relating to the treatment provided to Patient Y while he was admitted in Hospital. Prior to attending at that interview, Dr. X had reviewed the College's copy of the Hospital chart relating to Patient Y.

Sometime after the interview of October 29, 2018, Dr. X was diagnosed with a serious medical condition. As a result, Dr. X has limited recollection of the care provided to Patient Y in November 2015 and of Dr. Dhalla's involvement in that case. The prospect of testifying in these proceedings has caused Dr. X to experience anxiety, and in the opinion of Dr. X's physician, has been interfering with Dr. X's recovery.

Copies of the College's initial written inquiries to Dr. X, Dr. X's letter dated September 8, 2017 responding to those inquiries, and the transcript of Dr. X's interview of October 29, 2018, are exhibits to Dr. X's Affidavit sworn September 5, 2019.

Counsel for the Investigation Committee, in his submissions in support of the motion to have Dr. X's evidence submitted by way of the Affidavit of September 5, 2019, made two acknowledgements at the beginning of his remarks, which were as follows:

1. The Investigation Committee would have preferred Dr. X to testify rather than introducing Dr. X's evidence by way of Affidavit; and

2. Portions of the transcript of Dr. X's interview of October 29, 2018 must be excluded in any event because those portions include comments on matters that were not within Dr. X's personal knowledge and are hearsay.

Nonetheless, counsel for the Investigation Committee argued that Dr. X's evidence should be allowed by way of Affidavit for several reasons:

(i) Dr. X's evidence is undoubtedly relevant to the issues involved in these proceedings and is arguably relevant to some of the critically important issues in these proceedings, including all three of the specific allegations comprising charge 1. Indeed, the Investigation Committee asserts that Dr. X's evidence is critical to a proper understanding of what happened to Patient Y at the Hospital while under Dr. Dhalla's care;

(ii) Dr. X's evidence, by way of Affidavit, is reliable and includes the detailed interview of Dr. X conducted by the College, following a review of important portions of the medical records relating to Patient Y. Dr. X's Affidavit will also be supported by Dr. X's own chart notes. In contrast, Dr. X's personal testimony, if given in these proceedings, would be much less reliable, given Dr. X's diminished recollection of events as a result of the medical condition;

(iii) The Panel has the authority and jurisdiction to admit Dr. X's evidence by way of Affidavit. Section 59.1(1) of *The Medical Act* stipulates that evidence may be given at a hearing of a panel, either orally or by Affidavit or both, subject to the limitation that a member's license or registration cannot be suspended or cancelled on Affidavit evidence alone. Counsel for the Investigation Committee also submitted that, even according to the more exacting standard that would be applicable in a court proceeding, the Affidavit of Dr. X would be admissible pursuant to the conditions outlined in subsections 58(1) and 58(2) of *The Manitoba Evidence Act*;

(iv) The Investigation Committee not only argued that the Affidavit of Dr. X sworn September 5, 2019 should be admitted, but also argued that it should be given significant weight, given the factors supporting its reliability as outlined above and that Dr. X's Affidavit is corroborated by the contents of the medical chart;

(v) In terms of potential prejudice to Dr. Dhalla, the Investigation Committee acknowledged that Dr. Dhalla may be prejudiced by the admission of Dr. X's evidence by Affidavit, because such evidence would not be subject to cross-examination. However, the Investigation Committee submitted that the effectiveness of any cross-examination in this case would be limited in any event, as a result of the diminished memory of Dr. X. Moreover, Dr. Dhalla would have the right to cross-examine other witnesses providing evidence contrary to his position and to testify himself with respect to any and all

matters within his knowledge that are referred to in Dr. X's Affidavit and the exhibits thereto; and

Given all of the foregoing, the Investigation Committee urged the Panel to exercise its discretion to admit the Affidavit of Dr. X sworn September 5, 2019 and to give it significant weight.

Dr. Dhalla strenuously opposed the motion to admit Dr. X's evidence by way of Affidavit, arguing that:

(i) Although the Panel has the discretion to admit the Affidavit, it should not. Dr. X's Affidavit is hearsay and there are inherent problems associated with hearsay evidence;

(ii) The motion to admit Dr. X's evidence by way of Affidavit is not simply "unusual" (as described by counsel for the Investigation Committee), it is "extraordinary";

(iii) Depriving Dr. Dhalla and his counsel of the right to cross-examine Dr. X on the evidence referred to in the exhibits to Dr. X's Affidavit, will constitute a serious breach of the rules of natural justice and the requirements of administrative/procedural fairness. Cross-examination in this case would not merely be a test of Dr. X's memory, or the accuracy and comprehensiveness of Dr. X's notes or chart entries, it would also be an opportunity for counsel for Dr. Dhalla to test, challenge and/or undermine Dr. X's knowledge and expertise, and to compare Dr. X's knowledge and expertise with that of Dr. Dhalla. Furthermore, a cross-examination would explore the experience of Dr. X in dealing with similar situations. Similarly, a cross-examination of Dr. X would be an opportunity to determine whether Dr. X's evidence was consistent with some or all of the rest of the documentary evidence. Moreover, in cross-examination, propositions could be put to Dr. X, with which Dr. X might agree and which might be favourable

to Dr. Dhalla. According to counsel for Dr. Dhalla, given the nature of Dr. X's evidence, all of the above-noted elements of a cross-examination are critically important to affording Dr. Dhalla a fair hearing;

(iv) The requirements for natural justice and administrative/procedural fairness in these proceedings are very high because the potential consequences for Dr. Dhalla are so important, not only for his reputation, but potentially for his ability to continue to practice medicine as a general surgeon;

(v) The Affidavit evidence of Dr. X will not be as reliable as suggested by the Investigation Committee. No information has been made available as to when Dr. X's medical condition began to affect Dr. X's recollection of events. It is therefore possible that Dr. X's memory had been adversely affected by the time of the interview with the College (October 2018), almost three years after the events in question). It is also significant that the chart which Dr. X reviewed prior to the interview with the College was not complete;

(vi) The evidence of Dr. X is not "necessary". There is an extensive, contemporaneous record in the medical chart, which will be introduced into evidence, which chronicles the care received by Patient Y at the Hospital. Evidence will also be forthcoming from other nurses and doctors involved in Patient Y's care; and

(vii) Dr. X's diminished recollection of events, and whatever anxiety Dr. X may be experiencing at the prospect of testifying, are not sufficiently concerning, so as to justify seriously prejudicing Dr. Dhalla's right to a fair hearing.

The Panel considered the foregoing submissions and the authorities referred to by the parties in their respective Motions Briefs. In doing so, the Panel was aware that Dr. X's Affidavit of September 5, 2019 is hearsay evidence, and that in certain circumstances, the acceptance of hearsay evidence can result in a denial of natural justice or a breach of the standards of administrative or procedural fairness.

The Panel ultimately decided to permit the evidence of Dr. X to be admitted by way of the Affidavit of September 5, 2019. The Panel's reasoning was as follows:

(i) In a letter from a physician providing care to Dr. X, dated July 4, 2019 (Exhibit "E" to Dr. X's Affidavit of September 5, 2019), that physician referred to Dr. X's "limited recollection of the events", and that the prospect of testifying "is interfering with [Dr. X's recovery]". Counsel for the Investigation Committee, as part of his rebuttal remarks, indicated that, as a result of the medical concerns expressed by Dr. X's treating physician, the Investigation Committee would not call Dr. X as a witness to testify, regardless of the Panel's ruling on the admissibility of Dr. X's Affidavit;

(ii) The Panel was satisfied that Dr. X's evidence is relevant to some of the important issues in these proceedings. The Panel's truth seeking function would therefore be enhanced by receiving the evidence of Dr. X even, if only, by way of Affidavit;

(iii) The Panel recognized that admitting Dr. X's evidence by way of Affidavit could be potentially prejudicial to Dr. Dhalla. However, the evidence from other "fact" witnesses, including nurses, other doctors, and Dr. Dhalla himself, along with the entire medical chart (consisting of over 480 pages) will also be admitted into evidence in these proceedings. The Panel therefore concluded it will have an extensive record of the factual context of these matters, and will be able to fairly assess the Affidavit evidence of Dr. X, within that factual context;

(iv) The Panel recognized the legitimacy of Dr. Dhalla's comments about the many and varied purposes of cross-examination and the disadvantages to Dr. Dhalla of his counsel not being able to explore issues such as Dr. X's background and experience, Dr. X's knowledge relative to Dr. Dhalla's knowledge and Dr. X's experience in similar situations. The Panel nonetheless concluded that those disadvantages could be addressed by

the Panel assessing Dr. X's evidence with skepticism, recognizing that it will not have been challenged or tested by cross-examination;

(v) The Panel has medical expertise. Two of its members have extensive surgical knowledge and experience. Such knowledge and experience will assist the Panel in assessing the Affidavit evidence of Dr. X in the context of all of the other evidence in these proceedings, including the opinion evidence to be offered by expert witnesses; and

(vi) Administrative and procedural fairness is of great importance in these proceedings. The protection of the public and the maintenance of the standards of the medical profession are also important. The Panel concluded that a proper balancing of those interests can be best achieved in these proceedings by permitting Dr. X's evidence to be admitted by way of the Affidavit of September 5, 2019 and by assessing that Affidavit evidence in the context of all of the other documentary, factual and opinion evidence which will be available to the Panel, recognizing that the Affidavit evidence will not have been challenged or tested by cross-examination.

Accordingly, the Panel granted the Investigation Committee's motion and permitted the evidence of Dr. X to be admitted by way of the Affidavit of September 5, 2019.

OVERVIEW

This case involves a tragic series of events, following the admission of Patient Y into the Hospital on November 5, 2015 under the care of Dr. Dhalla, and culminating in Patient Y's death on November 20, 2015. The focus of these proceedings, was on the relevant events as defined by the Notice of Inquiry, which occurred between November 5 and November 12, 2015.

Between November 5 and November 12, 2015, various physicians were involved in Patient Y's care, including Dr. Dhalla, Dr. X, Surgeon 1, Physician 1, Surgeon 2, and Surgeon 3.

Patient Y underwent several procedures, including surgical procedures performed by Dr. Dhalla, Surgeon 1, Surgeon 2, and Surgeon 3.

Both the Investigation Committee and Dr. Dhalla retained experts to express opinions in support of their respective positions. Dr. Brent Zabolotny was retained by the Investigation Committee and Dr. Ashley Vergis was retained on behalf of Dr. Dhalla.

Evidence in these proceedings was introduced before the Panel on September 12, 13, 17, 18, 19 and 20, 2019. Extensive and extremely helpful written submissions were provided by the parties to the Panel pursuant to an agreed upon schedule in November and December 2019. Oral arguments were made before the Panel on December 17, 2019.

In addition to the Affidavit of September 5, 2019 from Dr. X, the evidence in these proceedings included 20 exhibits, including the medical chart for Patient Y (consisting of 484 pages), two reports from Dr. Zabolotny, and one report from Dr. Vergis.

The following witnesses testified at the hearing:

- Nurse H
- Nurse C
- Dr. Zabolotny
- Surgeon 1
- Dr. Dhalla
- Dr. Vergis

A Statement of Agreed Facts (Exhibit 5) relating to Dr. C's involvement was admitted into evidence with Dr. Dhalla's consent.

THE BACKGROUND FACTS

Some of the important factual issues in these proceedings are contentious. However, many of the background facts are uncontentious. The salient background facts, whether contentious or uncontentious, are summarized below and provide a context for the analysis which follows.

1. Patient Y, a 59 year old male, presented to the Emergency Department at the Hospital with abdominal pain, nausea and vomiting on the evening of Wednesday, November 4, 2015. He had been symptomatic for approximately one week. Patient Y had a surgical history of laparoscopic large hiatus hernia repair which had been performed in March, 2013.

2. Dr. Dhalla was on call on November 4/5, 2015. He assessed Patient Y in the early morning hours of November 5, 2015. Patient Y was diagnosed with a gastric volvulus and admitted to the Hospital under Dr. Dhalla's care.

3. Patient Y was assessed. The treatment plan was to allow gastric decompression via a nasogastric tube (NG tube), followed by an upper GI endoscopy in an attempt to reduce the volvulus, failing which the patient would require surgery. Although it was recognized by Dr. Dhalla that the endoscopy would likely not be successful in reducing the volvulus, it is acknowledged by both parties and their respective experts that the decision to proceed with an endoscopic reduction was reasonable.

4. Dr. Dhalla undertook the endoscopy procedure on Monday, November 9, 2015. Patient Y's medical chart indicates the procedure commenced at 16:22 and ended at 17:04. Dr. Dhalla was unable to completely reduce the volvulus. During the course of the procedure Dr. Dhalla noted that the stomach was "dusky" in colour and that a gastric ulcer was present. An NG tube was reinserted at the end of the procedure.

5. At the end of the endoscopy procedure, Dr. Dhalla's plan was for the patient to be stabilized and resuscitated prior to a return at the appropriate time to the Operating Room for a surgical reduction of the volvulus.

6. Dr. Dhalla testified that at the conclusion of the endoscopy, he remained in the endoscopy suite to complete his handwritten notes and to dictate the operating report, at which time he left the endoscopy suite. The electronic dictation stamp indicates Dr. Dhalla finished his dictation at 17:10.

7. There is a significant dispute between the parties as to the condition of Patient Y when Dr. Dhalla departed the endoscopy suite. Dr. Dhalla testified that the patient was “very stable” when he left the endoscopy suite. In contrast the Investigation Committee asserts that Patient Y was not stable and had developed significant pain and abdominal distention before Dr. Dhalla left the endoscopy suite. The Investigation Committee relies in part on information from Patient Y’s medical chart which indicates that Patient Y’s vital signs, at or around the time the endoscopy procedure was finishing, were unstable and significantly abnormal.

8. The vital signs monitoring strip at 17:00 indicated a pulse rate of 107, oxygen saturation of 66, blood pressure of 159/122 and a CO_2 level of 26. At 17:03 the vital signs monitoring strip indicated a pulse rate of 128 and a CO_2 level of 7 with no readings for oxygen saturation or blood pressure.

9. Regrettably, there is no printout of vital signs from 17:04 to 17:25. Dr. Dhalla testified that some of the CO_2 and oxygen saturation readings may have been distorted during the time he was replacing the NG tube and that for some period of time “. . . instruments could be off”. There was no adequate explanation provided in the evidence for the lack of data regarding the patient’s vital signs from 17:04 to 17:25.

10. Sometime after Dr. Dhalla departed the endoscopy suite, he was paged to return by nursing staff. He returned to the suite at 17:40. Upon his return, chest and abdominal x-rays were ordered. Dr. Dhalla recognized a tension pneumoperitoneum and diagnosed acute abdominal compartment syndrome. Dr. Dhalla promptly addressed the tension pneumoperitoneum by needle decompression, performed in the endoscopy suite.

11. In his testimony, Dr. Dhalla explained abdominal compartment syndrome and commented on Dr. Zabolotny’s description of the syndrome as follows:

> "Abdominal compartment syndrome is a constellation of multiple findings, including change of vital signs, that also, because of the box that was described by Dr. Zabolotny very eloquently, I am going to use that same analogy, it is a box, and you have only limited space. So, if air is being constantly introduced from outside in, that means the box can't expand, so something has to give. So that is in the form of derangement, so you have compressing the venous return, also compressing arterial inflow, so you are damaging, intra-abdominal organs, including kidney, liver, and, not only that, you are also affecting perfusion to extremities, and this is being demonstrated to me, by the nurses with a mottled extremities at that time."

12. Dr. X, who was the Intensive Care Unit (ICU) attending physician, was paged to the endoscopy suite by Dr. Dhalla for a consultation at approximately 17:55 and arrived at the suite at 18:10. In Dr. X's Affidavit, the following is stated with respect to the consultation with Dr. Dhalla:

- Patient Y was minimally responsive and in respiratory distress.
- Dr. Dhalla informed Dr. X that he had performed right upper quadrant needle decompression to address abdominal compartment syndrome related to endoscopy gas exiting a gastrointestinal perforation.
- Dr. X determined that Patient Y would need to be intubated emergently.
- Dr. X contacted the ICU to get Nursing and Respiratory Therapy staff to prepare to receive a critically ill patient.

13. In Dr. X's Affidavit it was also stated that as preparations were being made to transfer Patient Y to the ICU, Dr. X spoke with Dr. Dhalla regarding his plan for the repair of Patient Y's gastric perforation and the reduction of the gastric volvulus. In that regard Dr. X's Affidavit evidence was that Dr. Dhalla stated that he wanted to wait and stabilize Patient Y prior to going to the OR. In the short term, Dr. X agreed to take Patient Y to the ICU in order to stabilize his respiratory status and hemodynamics. According to Dr. X's Affidavit, Dr. Dhalla recognized that Patient Y would require surgical

intervention with respect to the gastric volvulus and hiatus hernia but did not provide a specific timeline.

14. Dr. Dhalla testified in the proceedings that his plan was to operate on Patient Y once Patient Y was stabilized and after he had been properly resuscitated, but that he (Dr. Dhalla) would intervene emergently, if Patient Y's lactate levels increased.

15. Patient Y was transferred to the ICU, at approximately 18:20 on November 9, 2015. Patient Y was placed on ICU monitors, started on phenylephrine IV to maintain blood pressure and an IV fluid bolus was given. Patient Y was intubated and broad spectrum antimicrobials were administered. An arterial line was inserted. Dr. X noted in Patient Y's medical chart that the endoscopy had been "eventful for perforation and ischemic stomach". Dr. X noted an impression of Patient Y's condition as being "metabolic acidosis, abdominal compartment syndrome and ischemic stomach secondary to gastric ulcer and volvulus". In contrast, Dr. Dhalla's report at the end of the procedure refers to "dusky colour in the stomach", based on his observation of the gastric mucosa (the inner lining of the stomach) which is what he would have seen during the endoscopy. Noting a dusky colour in the gastric mucosa is not equivalent to a diagnosis of a non-viable ischemic stomach.

16. While Patient Y was in the ICU Dr. X became concerned about his condition and accordingly telephoned Dr. Dhalla at approximately 21:15. Dr. X advised Dr. Dhalla of concerns that Patient Y was displaying signs of early multi-system organ failure, including abnormal liver enzyme profile, early renal failure and hyperkalemia. Serum lactates had fallen slightly. According to Dr. X's chart notes, Dr. Dhalla declined to take Patient Y to the operating room indicating that he would intervene emergently if lactate levels increased. A second phone call took place between Dr. X and Dr. Dhalla at 21:30 on November 9, in which Dr. X notified Dr. Dhalla that blood was visible from the NG tube and that an elevated white blood cell count was noted from Patient Y's lab work. According to Dr. X's chart note, Dr. Dhalla indicated he wished to continue medical management and declined Dr. X's specific request that Dr. Dhalla take Patient Y to the OR.

17. In a third phone call between Dr. X and Dr. Dhalla which occurred at approximately 00:40 on November 10, 2015, Dr. X advised that Patient Y was further deteriorating; his lactate levels were rising and operative intervention should occur. Dr. Dhalla indicated that the OR team should be mobilized and that he would intervene surgically.

18. There is a difference of opinion between the experts relating to sepsis as a critical concern in Patient Y's condition on November 9/10, 2015. Dr. Zabolotny opined on behalf of the Investigation Committee that Patient Y's high white blood cell count (26.6) indicated a tremendous immune response, underscoring his concern that the perforation could be a source of contamination, infection and sepsis. Dr. Zabolotny maintained that septic shock would have been a concern from the time a GI perforation was identified. In contrast, Dr. Vergis, opining on behalf of Dr. Dhalla, testified that in his opinion sepsis in Patient Y was unlikely, observing that an increased white blood cell count could be consistent with inflammation or other factors which would likely have been present in this case. Similarly, there was a difference between Dr. Zabolotny and Dr. Vergis with respect to ischemia. Dr. Zabolotny testified that there were multiple factors indicating ischemia, signifying a critically ill patient in need of surgical intervention to address the issues that were causing the ischemic changes. Dr. Vergis opined that he did not believe that ischemia was driving Patient Y's illness on the evening of November 9, 2015 and that taking the patient to the operating room immediately after the needle compression "would have had an immediately worse outcome".

19. In Dr. Dhalla's operative report relating to the November 10 surgery, the preoperative diagnosis is basically the indication for this surgery and is listed as "gastric volvulus/septic shock". This indicates the established diagnosis of "gastric volvulus" and also indicates that Dr. Dhalla recognized sepsis as a possible issue and a possible cause for Patient Y's deterioration by 00:15 hours on November 10, 2015. The patient was therefore brought to the Operating Room for an exploratory laparotomy as the patient had deteriorated in the Intensive Care Unit exhibiting deteriorating hemodynamic stability, worsening lactic acidosis and a rising white blood cell count.

20. Patient Y was operated upon by Dr. Dhalla as an urgent case on November 10, 2015 at 1:30. In the medical chart Dr. Dhalla noted that there was a recurrent hiatal hernia with incarceration of the stomach which was twisted, in keeping with a diagnosis of gastric volvulus. The fundoplication, performed during the 2013 hiatal hernia repair had to be divided to allow reduction of the stomach to its intra-abdominal location and to allow for the untwisting of the gastric volvulus. Dr. Dhalla also identified a perforation of the stomach which was repaired, with two sutures. The stomach was observed to be "very dusky" during the procedure. Dr. Dhalla stated that fixing the volvulus restored blood flow to the stomach and bowel. The medical file indicates that the patient was hemodynamically quite unstable during the entire course of this operative procedure. In view of the severe instability of the patient, Dr. Dhalla chose not to do a primary closure of the abdominal wound, but elected to use VAC ABThera dressing to manage the open incision. The patient returned to the ICU in about the same unstable condition that he had been in prior to the surgery.

21. A swab taken from the abdomen during Patient Y's surgical procedure was positive for various microbes capable of establishing infection. This is a fact upon which the Investigation Committee relies in asserting that Patient Y had likely experienced a significant spillage of gastric contents.

22. The medical chart relating to Patient Y indicates that after the November 10 surgery performed by Dr. Dhalla, the clinical status of Patient Y remained unstable. Dr. X noted that Patient Y arrived back in the ICU around 4:00 in a state of "extremis" and "profound SIRs (Systemic Inflammatory Response Syndrome) response and likely septic shock from perforated ischemic stomach/stomach herniation and effects of CO_2 pneumoperitoneum/abdominal compartment syndrome post endoscopy. . . ".

23. After the November 10 surgery performed by Dr. Dhalla, Patient Y experienced very significant ongoing bleeding and required transfusions. To illustrate, it is noted in the medical record that by 7:30 hours on November 10, 2015 (four hours after the earlier surgery), Patient Y had received: "5 units of RBC's; 1 litre of FFP, 1 adult pool

of platelets and 8 units of cryoprecipitate". During the remainder of November 10, very significant bleeding continued and required ongoing transfusions.

24. Later on November 10, 2015, Dr. Dhalla assessed Patient Y in the ICU and decided that it was neither necessary nor advisable to take Patient Y back to the OR. According to the Affidavit of Dr. X, Dr. Dhalla would not take Patient Y back to the OR because of his profound coagulopathy and a concern that Patient Y would exsanguinate in the operating room.

25. At approximately 22:45 on November 10, 2015, Dr. X, because of significant concerns about Patient Y's ongoing blood loss, contacted the on-call general surgeon at the Hospital seeking assistance. The on-call surgeon, Surgeon 2, indicated that Surgeon 1 might be covering Dr. Dhalla's hospital patients. Dr. X contacted Surgeon 1 who confirmed that he was covering for Dr. Dhalla and that Dr. Dhalla had provided him with some information about Patient Y. Surgeon 1 advised Dr. X to reduce the pressure on the VAC ABThera dressing and that he (Surgeon 1) would assess Patient Y in the morning.

26. November 11, 2015 was Remembrance Day, which Dr. Dhalla was intending to take as a holiday. Surgeon 1 assessed Patient Y on the morning of November 11, 2015 and at Dr. X's request conducted a gastroscopy to establish the viability of the stomach. Surgeon 1 concluded that Patient Y's stomach was viable and recommended continuing with medical treatment.

27. During the remainder of November 11, 2015, attempts were made to strike a balance between the rising intra-abdominal pressure (caused by increased swelling and bleeding) and the negative pressure of the VAC dressing, in the hope of reducing the bleeding. Significant efforts were also being made to meet ongoing blood requirements due to continuing blood loss. Dr. X contacted Dr. Dhalla at 19:30 on November 11 and Dr. Dhalla provided advice with respect to VAC pressure monitoring.

28. Surgeon 1 was consulted at 22:30 on November 11, 2015, in view of the continued massive bleeding. Shortly thereafter, in the early morning of November 12, he

performed an exploratory laparotomy on Patient Y in the ICU and found six litres of blood. Ongoing bleeding was observed coming from the right upper quadrant of the abdomen. Surgeon 1 evacuated the blood and "packed" the right upper quadrant of Patient Y's abdomen. Surgeon 1 also reattached the VAC ABThera dressing. Thereafter, transfusions continued at one unit per hour. In Surgeon 1's operative note he stated:

> "The edges of the incision were dry. No DIC bleeding. The abdomen had a huge blot clot in the right upper quadrant. The clot was broken down and removed. There was blood in all four quadrants of the abdomen and the pelvis. All of the blood clot and blood was evacuated. The blood continued to ooze from the right upper quadrant when the area was palpated. Apparently the spleen was floating but the surface was smooth and no breaks in the surface. The bleeding slowed down dramatically with packing with abdominal sponges. The peritoneal cavity then was irrigated with saline and suction. Five sponges were packed in the right upper quadrant and left there. The amount of blood removed from the abdomen was about 6 litres."

29. It was Surgeon 1's expectation that Dr. Dhalla would conduct a follow-up surgery to address Patient Y's bleeding.

30. During the morning of November 12, 2015, Patient Y continued to bleed requiring transfusion of one unit of RBC, and 500 mls FFP per hour. A review of the medical records indicates that between November 10 and November 12, in a period of less than 48 hours, Patient Y received in excess of 50 units of RBC, and multiple units of FFP and cryoprecipitate. The medical chart indicates that blood product availability was becoming a concern.

31. Based on the Affidavit of Dr. X, Dr. Dhalla attended in the ICU at 8:30 at Dr. X's request. Dr. X asked Dr. Dhalla to defer a scheduled "Whipple" procedure in order that he (Dr. Dhalla) could attend to Patient Y. A Whipple procedure is also known as a pancreaticoduodenectomy. It is usually an elective procedure, but is complex and takes a significant amount of time, usually approximately six hours. Dr. Dhalla declined to defer the "Whipple" procedure and provided advice concerning pressure monitoring and manipulation of the VAC dressing with respect to Patient Y.

32. Dr. Dhalla departed the ICU in order to conduct the “Whipple” procedure. Dr. X then spoke to Dr. C, the ICU Medical Director, and the physician who was then replacing Dr. X as the attending physician in the ICU. Physician 1 concluded that Patient Y required an exploratory laparotomy and possible additional thoracotomy. Physician 1 attended at the operating room where Dr. Dhalla was working. Physician 1 advised Dr. Dhalla that Patient Y required immediate surgery for ongoing bleeding and that a surgeon was required immediately for Patient Y. Dr. Dhalla agreed and told Physician 1 to contact Surgeon 2 for the required surgery.

33. Surgeon 2, assisted by Surgeon 3, brought Patient Y to the Operating Room on the afternoon of November 12, 2015 for a laparotomy, thoracotomy, and control of bleeding. The procedure, to allow enhanced visualization of the area of concern, was performed utilizing a thoraco-abdominal incision. The short gastric vessels were identified as the major source of bleeding, and controlled with a ligature. A laceration of the liver was also repaired. A chest tube was placed and the chest and abdominal wounds were closed in a standard manner. The operative report indicates that adequate control of the intra-abdominal bleeding was achieved.

34. Patient Y continued to experience the grave effects of multi organ failure and died on November 20, 2015.

ANALYSIS

Introductory Comments

Before setting forth an analysis of the allegations outlined in Charge 1(a), (b) and (c), two other issues warrant comment.

1. Dr. Dhalla has pled guilty to Charge 2, namely that he failed to adequately document his involvement in the care and management of Patient Y in the medical record. This plea of guilty to Charge 2 is an acknowledgement by Dr. Dhalla that his inadequate documentation relating to Patient Y constitutes an act of professional misconduct in and of itself, regardless of the findings which are made in relation to Charge 1. Adequate documentation is an essential element of proper patient care for many reasons, including

ensuring that other caregivers, including other physicians are adequately informed of the material facts relating to the previous diagnoses and treatment of the patient and of the treatment plan(s) at relevant points in time.

Dr. Dhalla's plea of guilty to Charge 2 will have consequences independent of the outcome of the proceedings relating to Charge 1. However, it must also be emphasized that Dr. Dhalla's inadequate documentation of his care and management of Patient Y also impacted the proceedings relating to Charge 1.

Inadequate documentation presented challenges for both of the experts, Dr. Zabolotny and Dr. Vergis, in assessing the background facts and formulating their opinions. In addition, the inadequate documentation impeded the Panel's efforts to assess whether some or all of the allegations contained in Charge 1(a), (b) and (c) had been proven.

By way of one example, a major issue in these proceedings is the time which elapsed between Patient Y's transfer to the ICU for ongoing care at 18:20 on November 9 (following the needle decompression to address the pneumoperitoneum) and the surgical intervention performed by Dr. Dhalla at approximately 1:30 on November 10. As pointed out by Dr. Zabolotny at p.3 of Exhibit 12, Dr. Dhalla did not include anything in Patient Y's chart to explain "why he did not press for an urgent operative intervention".

This deficiency in the documentation, which is the responsibility of Dr. Dhalla, presents a dilemma for the Panel. Is it appropriate in such circumstances to decide that a lack of explanation in the medical record should result in the conclusion that Dr. Dhalla made a serious error, or is the Panel entitled to examine other evidence to assess whether such a delay was reasonable? The Panel, although frustrated by the lack of documentation from Dr. Dhalla on this issue, did examine all of the evidence relating to the issue in order to assess the reasonableness of Dr. Dhalla's thought process and actions.

2. During the proceedings, the Panel noted that there may have been some imprecision in the use of the words “ischemia” and “ischemic”. Those words were frequently referred to in these proceedings, both in the evidence and in the written submissions of the parties. Clarification of the meaning of these words is in order.

Ischemia means a diminished blood supply to an organ. Ischemia may be partial or complete. The result is a decrease in the supply of oxygen and nutrients to the organ. Ischemia does not necessarily result in the complete death of an organ. However, it may significantly impair function. Ischemia does not necessarily mean that the affected organ is non-viable.

The acute abdominal compartment syndrome which Patient Y experienced on November 9 constituted a severe ischemic insult to several organs, including the stomach, the kidney, the liver, and likely other organs.

Dr. X focused frequently on ischemia, particularly of the stomach as the reason or a primary reason for Patient Y’s unstable status after November 9. However, the stomach is the most vascularized portion of the gastrointestinal tract and it is difficult to render the stomach non-viable. The ischemia of the other organs, as a result of the abdominal compartment syndrome was also a very significant problem in this case.

The physician members of the Panel note that it is possible that acute abdominal compartment syndrome may result in irreversible damage to abdominal organs (such as the liver, the kidneys, the small and large intestines, and/or the stomach), to the lungs, and to the lower extremities. Abdominal surgical intervention would allow inspection of the small and large intestines and the stomach to determine their viability, with the opportunity, if feasible, to remove portions that are not viable. However, it is probable that such surgery would not enable the physicians involved to either recognize any injuries to the lungs, kidneys or liver or to surgically correct any damage to the lungs, kidneys or liver.

Charge 1 of the Notice of Inquiry

Charge 1 includes three subparagraphs, (a), (b) and (c). All three of those subparagraphs contain specific allegations against Dr. Dhalla which must be considered in the context of the general allegation in the introductory paragraph of the charge. The general allegation is that between November 5 and November 12, 2015, Dr. Dhalla, in his overall treatment and management of Patient Y, displayed a lack of knowledge, skill and judgment in the practice of medicine, contravened specific articles in the Code of Conduct of the College and in By-Law 1 of the College, and committed acts of professional misconduct.

Charge 1(a) of the Notice of Inquiry

In summary, charge 1(a) alleges that Dr. Dhalla left the operating room (which in this instance was the endoscopy suite) without responding to Patient Y's abnormal vital signs and without ensuring the patient was in stable condition, thereby rendering himself "no longer immediately available to address a surgical complication that required urgent attention".

The surgical complication referred to in charge 1(a) is the tension pneumoperitoneum related to a gastrointestinal perforation.

The Investigation Committee is not alleging a deficiency in the manner in which Dr. Dhalla performed the endoscopy. In Dr. Zabolotny's report (Exhibit 12), he specifically stated: "I cannot find fault with Dr. Dhalla's endoscopic skills".

Some additional background facts are noteworthy. The procedure was done using intravenous sedation. It commenced at 16:22 and concluded at 17:04. This was a longer than normal endoscopy procedure requiring more than the usual sedation. This likely indicates that Dr. Dhalla was diligently attempting to reduce the volvulus (namely to undo the volvulus and to return the stomach to its normal anatomic location in the abdomen). However, because this was not a routine endoscopic procedure, it is arguable that more than the usual post-endoscopy assessment of the patient should have been undertaken by Dr. Dhalla.

As noted above, the procedure was not successful in correcting the gastric volvulus. A nasal gastric tube was reinserted at the end of the procedure.

The evidence on which the Investigation Committee relies in support of the allegations that Dr. Dhalla failed to respond to Patient Y's abnormal vital signs and that Dr. Dhalla left the endoscopy suite without ensuring that Patient Y was in a stable condition, primarily consists of the following:

(a) The evidence from Patient Y's medical chart, which the Investigation Committee alleges establishes that Patient Y's vital signs at or around the time the endoscopy was concluding were significantly abnormal. The Investigation Committee asserts that the vital signs immediately before Dr. Dhalla departed the endoscopy suite indicated that Patient Y was experiencing hypoxia (an oxygen deficiency), tachycardia (a rapid heart rate) and elevated blood pressure;

(b) Patient Y was described as being in discomfort and his abdomen as being distended and taut by the end of the endoscopy. The Investigation Committee alleges that Dr. Dhalla was aware of the patient's discomfort, his distended abdomen and the abnormal vital signs before he left the endoscopy suite; and

(c) The concession made by Dr. Vergis in cross-examination that if a physician had been aware of those abnormal vital signs and did not take steps to verify their reliability and did not undertake actions based on verified vital signs, such omissions would constitute a failure to properly manage the patient.

With respect to the Investigation Committee's allegations that Patient Y was experiencing tachycardia and elevated blood pressure prior to Dr. Dhalla leaving the endoscopy suite, some variation in pulse rate and blood pressure would be expected during a prolonged endoscopy. The Panel, therefore, did not attach great significance to

the vital signs readings in those categories prior to Dr. Dhalla's departure. The issue of a potential oxygen deficiency (hypoxia) will be discussed below.

Dr. Dhalla's own evidence was that his usual practice, which he believes he followed in this case, was to stay in the room after the conclusion of the procedure to complete his handwritten report and dictate his operating report. This affords him time to also assess the patient. Dr. Dhalla testified that Patient Y was stable when he left the endoscopy suite. Dr. Dhalla also indicated that he would not have kept writing his report or left the suite, if the patient had not been stable.

A major challenge associated with charge 1(a) is determining precisely when Patient Y began to deteriorate and determining whether Dr. Dhalla was aware of any seriously abnormal vital signs or other clinical signs of deterioration prior to leaving the endoscopy suite.

Nurse H was the nurse who assisted with the endoscopy procedure on November 9, 2015. She made notes, timed at 17:05. Part of her notes state that Patient Y was ". . . uncomfortable during scope. Abdomen was very distended and taut. Unable to get SAO_2 and B.P. results. Dr. Dhalla aware". The same notes refer to some vital signs recorded at 17:26 or later.

At p.121 of the medical chart (Exhibit 4), as part of the operative record, Nurse H recorded that a new NG tube was placed at 17:05. A review of pages 121 and 122 of the medical chart indicates that ordinary preparations were being made between 17:05 and 17:25 for a discharge of Patient Y from the endoscopy suite.

These entries are significant in at least two respects:

(i) Nurse H's note, timed at 17:05, likely constituted a summary of events commencing at 17:05 and lasting until the patient was eventually transferred to the ICU. Nurse H conceded that possibility in her testimony. She stated that it is possible she wrote most or all of the notes sometime after 17:26 or that she wrote some of the note, commencing at 17:05 but added additional entries after 17:26; and;

(ii) The content of pages 121 and 122 of the medical chart do not suggest that Nurse H was attending to an acute problem with the patient prior to Dr. Dhalla's departure from the endoscopy suite at around 17:10.

Regrettably, there was a gap in the vital signs strip between 17:05 and 17:25. The beginning of the gap period coincides with the reinsertion of a naso-gastric tube. Nurse H also testified that she would have restarted the recording on the strip when she had concerns about Patient Y's condition. The strip began recording again at 17:25. However, Dr. Dhalla had left the endoscopy suite at 17:10 and therefore would not have been aware of most of the concerning vital signs prior to his departure from the endoscopy suite.

There was a concerning vital sign recorded on the strip at 17:00, namely an oxygen saturation reading of "66" and unusual CO_2 reading of "26" at the same time. Dr. Vergis stated that in his opinion, the oxygen saturation reading could be considered a false reading. There was also a highly unusual CO_2 reading of "7" at 17:03.

In reference to some of the vital sign readings between 17:00 and 17:05, Dr. Dhalla speculated (because he had no specific recollection of these events) that he would have expected a patient to experience some discomfort and stress at the end of such a procedure and while a naso-gastric tube was being inserted. Such speculation, even if correct, does not explain an oxygen saturation reading of 66 at 17:00, several minutes before the insertion of a new naso-gastric tube. The CO_2 reading of 7 is so unusual, it may be explained by the measuring device being dislodged or detached from the patient.

In his testimony, Dr. Dhalla did not provide any information or explanation as to how he reacted, if at all, to the oxygen saturation reading of 66, or the unusual CO_2 readings, except to say that if the patient had been in respiratory distress between 17:00 and 17:05, he would not have inserted an naso-gastric tube, but would have instead applied a mask. Dr. Dhalla therefore assumed that the patient had not exhibited signs of respiratory distress at that time.

The strip was reactivated at 17:25 at which time Patient Y's vital signs were concerning and his condition was visibly deteriorating (e.g. his legs were discoloured and he was reported to be in respiratory distress).

The evidence does not establish precisely when Dr. Dhalla was paged to return to the endoscopy suite, but he returned by 17:40, i.e. without undue delay, regardless of when the page occurred.

In reaching its conclusion with respect to charge 1(a) the Panel has been mindful of the standard of proof which is to be applied in this case. The Investigation Committee must prove, on the balance of probabilities (i.e. that it is more likely than not) based on clear, convincing and cogent evidence that Dr. Dhalla failed to respond to Patient Y's abnormal vital signs and failed to ensure that Patient Y was in a stable condition prior to departing the endoscopy suite.

There is no suggestion that the endoscopy procedure itself was improperly performed. The evidence establishes that Dr. Dhalla made a concerted effort to reduce the volvulus endoscopically.

There is some evidence suggesting that Dr. Dhalla failed to respond to Patient Y's abnormal vital signs and that he failed to ensure that Patient Y was in a stable condition prior to departing the endoscopy suite. However, Dr. Dhalla's evidence was that the patient was stable or very stable when he left the endoscopy suite and he is adamant that he would not have left, if the patient had been struggling. Furthermore, the absence of readings on the vital signs monitoring strip from 17:05 to 17:25, meant that Dr. Dhalla was unaware of most of the concerning readings when he left the suite at around 17:10.

In terms of other signs of Patient Y's deteriorating condition, the notes of Nurse H at p.121 of Exhibit 4, do not suggest the patient was experiencing acute difficulties prior to Dr. Dhalla leaving the endoscopy suite. The best evidence surrounding Nurse H's note at 17:05 is that it was a summary of events likely taking place over an extended period and contains reference to events occurring at 17:26 and afterwards.

Therefore those notes cannot be relied upon to establish what was occurring and what Dr. Dhalla knew before leaving the endoscopy suite at 17:10.

Within the above-noted evidentiary context, there were two specific issues which presented significant challenges to the Panel. Those issues were:

(i) whether the evidence establishes that there were obvious physical signs that Patient Y was unstable prior to Dr. Dhalla leaving the endoscopy suite?

(ii) Whether Dr. Dhalla was aware of the oxygen saturation reading of 66 at 17:00, and if so, how he reacted to that reading?

With respect to obvious physical signs that Patient Y was unstable, Nurse H's note refers to Patient Y's abdomen being very distended and taut. Some distension of the abdomen would be expected after a lengthy endoscopy. Nurse H also noted that Dr. Dhalla "was aware" of the distension and of the unavailability of some vital sign results. However, for the reasons referred to earlier in these Reasons, that note cannot be relied upon to establish when Dr. Dhalla became aware of those matters. Dr. Dhalla's evidence was that the patient was not in respiratory distress between 17:00 and 17:05 (or he would not have inserted an NG tube) and that he was stable when he left the endoscopy suite at 17:10.

With respect to the oxygen saturation reading of 66 at 17:00 and the CO_2 reading of 7 at 17:03, the evidence does not conclusively establish that Dr. Dhalla was aware of those readings, but the Panel has proceeded on the basis that he either was aware or should have been aware of those readings. Dr. Dhalla stayed in the suite for several minutes thereafter, inserted the NG tube, completed his notes and dictated the

report. He considered the patient to be stable (indeed he stated ”very stable” in his testimony) when he left the suite.

Based on its review of all of the available evidence on these issues, it is the Panel’s conclusion that the standard of proof (the balance of probabilities) has not been met in relation to charge 1(a). As a result, the allegations against Dr. Dhalla as outlined in charge 1(a) are dismissed.

The Panel has reached its decision with respect to charge 1(a) advisedly and with reluctance. The Panel recognized that the endoscopy which Dr. Dhalla performed on Patient Y was not routine; it took longer and was performed under greater sedation than a usual endoscopy. There were also certain factors which in hindsight, can be regarded as contributing to a “perfect storm”, including the gap in the vital signs strip between 17:05 and 17:25, the fact that the procedure was performed at the end of the regular working day, resulting in less nursing supports being available when the procedure ended, and the patient not being promptly taken to a recovery room. (If he had been taken to a recovery room, the monitoring of his vital signs may have recommenced more promptly.)

In such circumstances, the Panel seriously considered whether there was a professional obligation on Dr. Dhalla, particularly in view of the oxygen saturation reading of 66 at 17:00, to ensure that Patient Y’s vital signs were being monitored and recorded and were within reasonable ranges, before he left the endoscopy suite at 17:10. Doing so would have represented a high level of care for Patient Y. It is regrettable that Dr. Dhalla did not undertake those measures in relation to Patient Y and not doing so constituted an error on his part.

The Panel was not provided with evidence by either party with respect to whether the Hospital had a specific policy or protocol in place with respect to post-endoscopy monitoring of vital signs. There was no opinion expressed by either of the experts in their reports relating to a standard which applies in Manitoba with respect to

the responsibility of a surgeon to ensure appropriate monitoring of vital signs following an endoscopy.

The Panel recognizes that Dr. Vergis addressed that issue in part in response to a question in cross-examination. However, the circumstances which prevailed on November 9, 2019, in relation to Patient Y, were unusual. The Panel has concluded that, given those unusual circumstances, the evidence in these proceedings is insufficient to establish that Dr. Dhalla's departure from the endoscopy suite at approximately 17:10, without ensuring Patient Y's vital signs were being monitored and were within reasonable ranges, warrants discipline..

Therefore, the allegations that Dr. Dhalla was guilty of professional misconduct, or of displaying a lack of knowledge, skill and judgment in the practice of medicine, or that he contravened any of the specified articles in the Code of Conduct or By-Law 1 of the College in relation to the particulars set forth in charge 1(a), have not been proven and are accordingly dismissed.

Charge 1(b) of the Notice of Inquiry

Charge 1(b) alleges that after a surgical complication had been identified and Patient Y had been transferred to the ICU, Dr. Dhalla failed to address the surgical complication in a timely manner and failed to appreciate and address a known perforation and evidence of ongoing ischemic changes.

The Panel notes that there were several complications arising from the endoscopy procedure, which were:

(i) A gastro-intestinal perforation;

(ii) Tension pneumoperitoneum;

(iii) Acute abdominal compartment syndrome;

(iv) Respiratory collapse;

(v) Circulatory collapse, i.e. shock.

Dr. Dhalla returned to the endoscopy suite at approximately 17:40. Chest and abdominal x-rays were immediately ordered. Dr. Dhalla recognized a tension pneumoperitoneum and correctly diagnosed acute abdominal compartment syndrome. He performed a needle decompression at 18:08 to address the pneumoperitoneum. There is no dispute that his response to the tension pneumoperitoneum was prompt and appropriate.

The respiratory collapse was managed promptly by the attending nurse applying a rebreathe mask, followed thereafter by the Intensive Care physician, Dr. X, intubating Patient Y and placing him on a ventilator. Similarly, the circulatory collapse was managed appropriately by Dr. X providing various resuscitative measures and supports in the ICU.

A considered assessment of Dr. Dhalla's response to the remaining complications, namely the perforation and the acute abdominal compartment syndrome, is difficult. The two issues are related.

The response to the perforation was the subject of two contradictory expert opinions.

Dr. Vergis opined in his report dated September 10, 2018 (Exhibit 19) as follows:

> "(1) Developing a perforation after gastroscopy is not an indication for emergent operative intervention. In most cases, this can be managed conservatively with naso-gastric decompression, admission, and close clinical observation/supportive care. Based on the record, this appears to have occurred for (Patient Y). Dr. Dhalla decompressed the tension pneumoperitoneum thus obviating the ACS. A naso-gastric tube was placed to prevent contamination and (Patient Y) was then taken to the ICU for supportive care."

In contrast, Dr. Zabolotny in his report received by the College on April 10, 2017 (Exhibit 12) stated:

> "The patient was transferred to the ICU for ongoing care. The transfer occurred at 18:20h per the nursing record. The patient was intubated because of respiratory compromise brought on by the pneumoperitoneum. He required phenylephrine to maintain an adequate blood pressure. His lactate levels were high and continued to rise throughout the evening. The fact that the patient had clear evidence of a perforation (pneumoperitoneum on x-ray) coupled with the fact that he had evidence of ongoing ischemic changes in light of a failed reduction of the gastric volvulus, in my opinion, both suggest the need for an urgent exploratory laparotomy. There are circumstances where surgery might need to be delayed. . . . There were however no circumstances documented in the ICU nursing notes, or the ICU physician notes that would explain why a 3 to 4 hour delay occurred before the patient was brought to the OR. . . . As there is no information in the chart that would explain a delay, I can only conclude that this delay was an error in judgment on the part of Dr. Dhalla. It is my opinion that (Patient Y) should have been taken to the OR as soon as possible after the pneumoperitoneum was recognized."

An important factor underlying Dr. Zabolotny's opinion was that the perforation could be a source of contamination and sepsis, potentially caused by spillage of stomach contents. Dr. Zabolotny was of the view that septic shock should have been a source of concern upon a perforation being recognized. Dr. Zabolotny's view was that urgent surgical intervention was indicated to locate and repair the perforation. In his testimony Dr. Zabolotny indicated that he had attempted to assess Dr. Dhalla's actions on the basis of the information which Dr. Dhalla would have had available to him at the material times. Dr. Zabolotny further testified that his stated concerns about sepsis were based on his belief that the perforation in this case could have been relatively large, thereby increasing the possibility of spillage of stomach contents.

The physician members of the Panel note that a pneumoperitoneum can be caused by a small perforation, no more than the size of a pinhole. Furthermore, Patient Y had had an NG tube emptying his stomach for approximately four days prior to the

endoscopy, which would have had the effect of keeping his stomach mostly empty of secretions. He had also been receiving Pantoloc, a medication to reduce gastric acid secretion since being admitted to the hospital. Once taken to the ICU, Patient Y was placed on an antibiotic to combat sepsis occurring as a result of the perforation. An NG tube was in place aspirating any gastric secretions which were accumulating. The physician members of the Panel also recognized the possibility that in some such cases surgery will not be required because normal body defences may heal the perforation. The Panel therefore does not agree with Dr. Zabolotny's opinion that the perforation of the stomach as a complication of the endoscopic procedure was a major factor leading to septic shock and the critical status of Patient Y at that time.

The Panel understands that Dr. Dhalla had himself referred to septic shock in his operative report relating to the November 10, 2015 surgery, recognizing that by 00:15 on November 10 septic shock was a possible cause of Patient Y's deterioration. Sepsis may well have been present at that time, not only as a result of some spillage of stomach contents, but also as a result of the damage to various organs caused by the acute abdominal compartment syndrome.

In view of the foregoing, the Panel prefers the opinion of Dr. Vergis, as referenced above, and as expanded upon in his September 10, 2018 report (Exhibit 19), in which he stated:

> "2. A plan is documented with clinical parameters which would warrant return to the operating room for further surgical management. In this case, those parameters included an increasing serum lactate or clinical deterioration. I feel that these parameters, especially clinical deterioration, are reasonable. Furthermore, I agree that it would be prudent to delay operative therapy in the acute setting to allow for anatomic and physiologic optimization prior to embarking on a complicated definitive surgery.
>
> The care plan, as outlined, reflects mature surgical planning as would be expected from a clinician with specific expertise in elective and emergent foregut conditions. I myself would have instituted this plan based on the clinical notation available. It is tempting for the experienced, but lay, general

> surgeon to criticize this approach given the ultimate outcome. However, it is easy to envisage an alternate scenario where operative intervention was pursued immediately and (Patient Y) developed surgical complications based on not pursuing conservative optimization measures. . . .
>
> 3. The clinical notation, bloodwork, and flowsheets indicate that (Patient Y) remained stable during the period of ICU admission until a decision being made to return to the OR. In fact, there is evidence during this time that end organ perfusion, as measured by serum lactate, anion gap, and ph were improving. It is difficult to argue that (Patient Y) warranted urgent operative management during the period of ICU admission until the time he was ultimately taken to the OR."

The perforation resulted in the acute abdominal compartment syndrome which was experienced by Patient Y. The syndrome was a very significant event. Dr. Zabolotny, in his direct examination helpfully outlined some of the serious consequences typically associated with the syndrome. Those consequences include:

(a) an increase in intra-abdominal pressure;

(b) a decrease in the return of blood from the lower body to the heart;

(c) a decrease of cardiac output;

(d) a decrease of blood flow to various organs including the kidney, the liver and the digestive tract, and the lower extremities;

(e) respiratory distress due to pressure on the diaphragm.

In summary, acute abdominal compartment syndrome may cause hemodynamic instability, altered heart rate, decreased blood pressure, reduced urine output and respiratory distress. The medical records relating to Patient Y contain much evidence that the acute abdominal compartment syndrome experienced by the patient was extremely serious and represented a severe ischemic insult to multiple organs. At 19:20 on November 9, serum k and creatinine levels were indicative of the onset of renal failure. Blood chemistry results which are more specific to the liver also suggested hepatic

injury. All of the above, along with abnormal ph and lactate levels were consistent with Patient Y being in shock. Furthermore, the low urine output while in the ICU was also consistent with renal failure and Patient Y being in shock. However, the physician members of the Panel recognize that surgery for the multi organ effects of the acute abdominal compartment syndrome is not the indicated treatment. Implementation of the resuscitative measures which were put in place in this case was a prudent course of action.

Dr. Vergis testified that one cannot predict the time that recovery from the trauma of acute abdominal compartment syndrome will take. In some cases resuscitative measures will produce positive results quickly, in other cases they may take longer to produce positive results and in some cases they may fail to produce positive results.

A reasonable interpretation of the discussions which occurred between Dr. X and Dr. Dhalla at 21:15 on November 9, 2015, is that a reasonable plan was being followed to continue resuscitative measures as long as improvement was occurring. Some improvement was occurring in the hours thereafter.

Dr. Dhalla followed that plan and made the necessary arrangements to operate on Patient Y at 1:30 on November 10, 2015, when lactate levels were rising and other clinical signs were consistent with the patient's worsening condition. During that surgery, Dr. Dhalla corrected the incarcerated hiatal hernia by returning the stomach to its abdominal location, untwisted the gastric volvulus and repaired the gastric perforation.

It is also noteworthy that whatever ongoing ischemic changes which Dr. X was documenting in the progress notes, had not resulted in loss of stomach viability. Therefore the charge that Dr. Dhalla did not respond to "ongoing ischemic changes" is not well founded.

In view of the foregoing, the Panel does <u>not</u> find that Dr. Dhalla failed to address the surgical complications referred to in a timely manner as alleged in charge 1(b). The Panel has therefore decided that the allegations against Dr. Dhalla in charge 1(b) must be dismissed.

Charge 1(c) of the Notice of Inquiry

Charge 1(c) alleges that on November 12, 2015, when Patient Y required urgent surgical intervention, Dr. Dhalla failed to ensure continuity of care and/or to provide appropriate assistance while he remained responsible for Patient Y.

Charge 1(c) is to be read in conjunction with the introductory paragraph of charge 1, which refers to events from November 5 to November 12, 2015 relating to the treatment and management of Patient Y for a gastric volvulus and subsequent complications (underlining added).

The Panel is satisfied that the allegations in charge 1(c) have been proven according to the applicable evidentiary standard and that Dr. Dhalla is guilty of professional misconduct, and of contravening Article 9 of the Code of Conduct, Schedule G to By-Law 1 of the College.

The significant bleeding which occurred immediately after the November 10 surgery performed by Dr. Dhalla and which continued thereafter throughout November 10 and 11 was not properly addressed by Dr. Dhalla. He acknowledged at the hearing that he was the physician most responsible for the care and treatment of Patient Y at all material times, including on November 11, when he (Dr. Dhalla) was not present at the Hospital. Notwithstanding Surgeon 1's surgical intervention early on November 12, including his evacuation of six litres of blood and his packing of the right upper quadrant of Patient Y's abdomen, significant bleeding continued.

Such massive, continuous bleeding, even after Surgeon 1's interventions early on November 12 required an immediate re-exploration to identify, and if possible, control any surgically correctable bleeding source. Patient Y received more than 50 units of RBC, in less than 48 hours between November 10 and November 12, 2015. Such transfusions are compelling evidence that Patient Y required a re-exploration and, if possible, a surgical correction of the bleeding source.

The Panel recognizes that, at least on November 10, there were concerns regarding the diagnosis of disseminated intravascular coagulation, which if present, would be considered a relative contra-indication to pursuing any immediate surgical intervention.

However, the Panel is not satisfied that whatever concerns Dr. Dhalla or Dr. X may have had with respect to DIC justified the delays in returning Patient Y to the Operating Room. Such delays were certainly not justified after Surgeon 1's intervention early on November 12. The Panel's reasoning is as follows:

(a) The Panel agrees with the opinion expressed by Dr. Zabolotny at page 4 in his report (Exhibit 12) wherein he stated with reference to a time period on November 10, 2015 after Dr. Dhalla's surgical intervention early that morning: "The high volume of blood loss, in my opinion, is inconsistent with bleeding that one might expect to see from the raw post-operative surfaces in the face of DIC induced hypocoagulation, and as such suggests another etiology";

(b) It is reasonable to conclude that at least, in part, the high volume blood loss and the subsequent massive transfusion protocol which was initiated may have subsequently resulted in a moderate degree coagulopathy in the absence of any diagnosis of DIC. However, such coagulopathy does not detract from the need for urgent surgical intervention;

(c) Coagulopathy may also occur due to decreased production of clotting factors which may occur after multi-organ injury, particularly hepatic injury and shock, such as Patient Y had experienced on November 9 and 10;

(d) Surgeon 1's November 12 operative note had stated: "the edges of the incision were dry. No DIC bleeding . . ." (underlining added);

(e) During the course of November 10, 11 and 12, 2015, fibrinogen levels and INR improved. It is unlikely those improvements would have occurred if DIC was occurring. On November 12, 2015 at 8:30 hours and for many hours

previously, coagulation tests, although not normal, were only minimally abnormal; and

(f) It is also significant that when Surgeon 1 undertook an exploratory procedure in the early hours of November 12, he removed blood clots from the abdomen, indicating that large clots had formed within the abdomen, a process that would probably not happen if active DIC was occurring.

Apart from the issue of DIC, there are other very concerning aspects relating to the care and continuity of care which Patient Y received up to and including the morning of November 12, 2015.

The Panel has concluded that Dr. Dhalla's advice to Dr. X at 8:30 on November 12 to reduce the pressure on the VAC dressing was inappropriate and ineffectual. The Panel accepts the evidence of Dr. Zabolotny that the application of a VAC dressing in the presence of active bleeding is contra-indicated. Alteration of VAC pressures is not a recognized method of controlling active bleeding. During the previous 48 hours, VAC pressures had been altered for Patient Y without success in controlling his bleeding.

In the circumstances which prevailed on the morning of November 12, Dr. Dhalla's advice to Dr. X at 8:30 to reduce the VAC pressure is more indicative of a reluctance to operate without valid reason, rather than a genuine attempt to care for a seriously ill patient.

The previous efforts by Surgeon 1 several hours earlier to stop Patient Y's hemorrhaging by "packing" had failed. Continued transfusion, without control of hemorrhaging, would not provide a successful outcome.

The Panel has concluded that further surgery on Patient Y should have been undertaken much sooner than the afternoon of November 12, 2015 (when Surgeon 2 and Surgeon 3 undertook their surgery). By the early morning of November 12, there can be no doubt that immediate surgical intervention was required. Indeed, it is very arguable that immediate surgical intervention was required from late in the morning on November 10, 2015 and continuously thereafter.

In those circumstances, Dr. Dhalla's decision to proceed with an elective Whipple procedure was deeply troubling. His decision effectively made him unavailable to attend to Patient Y, or to assist other physicians who were doing so, for a significant period of time (a Whipple procedure can usually be expected to last a minimum of six hours). Dr. Dhalla took no active steps for another surgeon to operate on Patient Y until confronted by Physician 1 in the Operating Room in which Dr. Dhalla was performing the Whipple procedure. If Dr. Dhalla was not intending to perform any surgery on Patient Y, he should have made much more detailed and thorough arrangements for another surgeon to be available to do so, and those arrangements should have been made far earlier than occurred in this case.

Article 9 of the Code of Conduct of the College (Schedule G of the College's By-Law #1) states that one of the general responsibilities of a physician is to "provide whatever appropriate assistance he/she can to any person with an urgent need for medical care".

The decisions and actions of Dr. Dhalla as outlined in relation to the allegations in charge 1(c) constituted a failure to provide appropriate assistance to Patient Y who was in urgent need of medical care, and therefore are a contravention of Article 9 of the Code of Conduct of the College.

Furthermore, Dr. Dhalla's delays in returning Patient Y to the Operating Room much sooner after Surgeon 1's interventions on November 11, 2015 (including his misplaced concerns relating to DIC), his advice to Dr. X to reduce the pressure on the VAC dressing at 8:30 on November 12, his failure to make appropriate arrangements for another surgeon to operate on Patient Y on November 11 or much earlier on

November 12, and his decision to undertake the Whipple procedure on the morning of November 12, individually and collectively constitute a failure to ensure continuity of care for Patient Y and to provide appropriate and required assistance to Patient Y at a time when Dr. Dhalla was responsible for the patient's care.

The Panel has determined that insofar as the allegation of professional misconduct is concerned, Dr. Dhalla's conduct and behaviour must be assessed against the standard of other surgeons possessing a reasonable level of knowledge, competence and skill expected of surgeons in this jurisdiction. The Panel finds that Dr. Dhalla's conduct and behaviour as outlined in relation to the allegations in charge 1(c) fall significantly short of that standard. Dr. Dhalla is therefore also guilty of professional misconduct.

The allegations against Dr. Dhalla, outlined in charge 1(c) have been proven according to the applicable evidentiary standard. Dr. Dhalla is guilty of professional misconduct and of contravening Article 9 of the Code of Conduct of the College (Schedule G of By-Law 1 of the College).

Error in Judgment

In the written and oral submissions made on behalf of Dr. Dhalla, an argument was made that if there were any shortcomings in Dr. Dhalla's decision making or actions in relation to his management of Patient Y, they did "not meet the threshold for disciplinable conduct". The submission was that at most, Dr. Dhalla may have made an "error in judgment".

In support of that argument, counsel for Dr. Dhalla submitted various authorities, one of which warrants specific comment.

In the Manitoba Court of Queen's Bench decision, *Campbell et al v. Jones et al: 2016 MBQB 10,* Chief Justice Joyal referred to the difference between an error in judgement and professional negligence and stated:

> "As it relates to the difference between an error in judgment and professional negligence, the Manitoba Court of Appeal in ***Gros v. Victoria General Hospital****, 2001 MBCA 134, 160 Man R. (2nd) 7* noted as follows:
>
> "The concept of error in judgment is not a new one in the field of medical malpractice litigation. The concept is well defined and historically situated in the 1956 decision of the Supreme Court of Canada in *Wilson v. Swanson [1956] S.C.R. 804 (at pages 812-13):*
>
> > An error in judgment has been distinguished from an act of unskillfulness or carelessness or due to a lack of knowledge. Although universally accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation."

In *Campbell et al v. Jones et al*, Chief Justice Joyal also commented upon the need to appreciate the role of professional judgment in medical care and also expressed a caution that the courts should "not judge the actions or inactions of medical professionals with the benefit of hindsight". He referred to other authorities from both England and Canada which have cautioned courts and tribunals against judging too harshly doctors who act in accordance with prevailing standards, and emphasizing that doctors are to be assessed according to the norms of the reasonably competent doctor in the same circumstances and are not to be held accountable for mistakes which are apparent only after the fact.

In reply to these submissions, the Investigation Committee referred to the Ontario case of *Keith v. Abraham 2011 CarswellOnt. 45,* in which Justice Brown held:

> "A physician is not to be held liable for a mere error of judgment which is distinguishable from professional fault. An error in judgment does not amount to negligence where the physician appropriately exercised clinical judgment."

It follows that physicians have the professional responsibility to appropriately exercise their clinical judgment, measured in relation to the knowledge and skills of a reasonably competent physician in like circumstances. If they fail to appropriately exercise their clinical judgment, they cannot excuse their actions as being errors of judgment.

In view of the above-noted statements from the authorities, the Panel acknowledges that Dr. Dhalla's departure from the endoscopy suite at approximately 17:10 on November 9, 2015, without ensuring that Patient Y's vital signs were being monitored, recorded, and were within reasonable ranges, does not meet the threshold for disciplinable conduct, and could be reasonably characterized as an "error in judgement".

However, the Panel has concluded that Dr. Dhalla did not appropriately exercise clinical judgement when he delayed in returning Patient Y to the Operating Room after Surgeon 1's intervention on November 12, 2015, when he advised Dr. X to reduce the pressure on the VAC dressing at 8:30 on November 12, when he failed to make appropriate arrangements for another surgeon to operate on Patient Y much earlier on November 12, and when he decided to undertake the Whipple procedure on November 12. None of those decisions and actions, either individually or collectively can be excused as "errors in judgement".

The Evidence of Dr. X

At the outset of these proceedings, Dr. Dhalla strenuously objected to admitting Dr. X's evidence by way of Affidavit on the grounds outlined elsewhere in the Reasons, emphasizing that depriving his counsel of his ability to cross examine Dr. X on Dr. X's evidence would constitute a serious breach of the rules of natural justice and administrative fairness and would be prejudicial to Dr. Dhalla's entitlement to a fair hearing.

Notwithstanding those arguable objections, the Panel decided to receive Dr. X's evidence by way of the Affidavit of September 5, 2019, for the reasons outlined in an earlier section of these Reasons.

Dr. X's evidence was useful to the Panel. The portions of that evidence which were the most useful, were some of Dr. X's entries in the medical chart of Patient Y. Those entries helped to fill in some gaps in the chronology of events and provided helpful information relating to Patient Y's status and condition between November 9 and the morning of November 12, 2015. Those entries were considered and evaluated by the Panel in relation to the balance of the medical chart and all of the other evidence in these proceedings.

On the basis of its assessment of all of the evidence, the Panel has concluded that Dr. X was a competent and caring ICU physician who was diligently attempting to provide appropriate care and ICU supports to Patient Y. Nonetheless, the Panel has concluded that there were instances in which Dr. X's assessments and recommendations may have been misguided, such as Dr. X's focus on gastric ischemia rather than a broader consideration of the overall ischemic effects of acute abdominal compartment syndrome. The Panel has also concluded that some of the communications between Dr. Dhalla and Dr. X were poor and that their communications did not allow for a coordinated approach to the care and management of Patient Y.

Dr. X's evidence played no part in the Panel's decision to dismiss the allegations against Dr. Dhalla outlined in charge 1(a).

The Panel differed with Dr. X with respect to its understanding and assessment of the evidence of "ongoing ischemic changes, and dismissed the allegations against Dr. Dhalla outlined in charge 1(b) based on its own assessment of all of the evidence relating to that charge.

The evidence of Dr. X was not a significant factor in the Panel's findings against Dr. Dhalla in relation to charge 1(c). The evidence which was the most significant to the Panel with respect to charge 1(c) was:

(a) All of the information in Patient Y's medical chart, including Dr. X's progress notes;

(b) The opinion of Dr. Zabolotny;

(c) Dr. Dhalla's own evidence, and particularly his lack of an adequate explanation of his decisions, either in the chart or in his testimony; and

(d) Surgeon 1's testimony that he (Surgeon 1) or another surgeon would be required to re-explore the patient as soon as possible, following the procedure which he had performed early on November 12.

Charge 2

At the outset of the hearing, Dr. Dhalla entered a plea of guilty to charge 2 in the Notice of Inquiry, thereby admitting that he had failed to adequately document his involvement in the care and management of Patient Y in the medical record.

Understandably, neither party made submissions with respect to charge 2 during this phase of the proceedings. The Panel will refrain from commenting on the significance of Dr. Dhalla's guilty plea to charge 2 until after it has had the benefit of the submissions of counsel with respect to the order or orders which may be appropriate pursuant to s.59.6(1) of the *Act*.

DECISION

The decision of the Inquiry Panel is as follows:

1. Dr. Dhalla is guilty of committing acts of professional misconduct and of contravening Article 9 of the Code of Conduct of the College (Schedule G to By-Law 1 of the College) in his treatment and management of Patient Y for a gastric volvulus and subsequent complications, between November 10 and November 12, 2015, as particularized in charge 1(c) of the Notice of Inquiry. During that period Patient Y required urgent surgical intervention and Dr. Dhalla failed to ensure continuity of care for Patient Y and failed to provide appropriate assistance in circumstances in which he remained responsible for Patient Y.

2. Dr. Dhalla is guilty of professional misconduct and of contravening Article 24.1 of By-Law 1 of the College by failing to adequately document his involvement in the care and management of Patient Y in the medical record.

3. A further hearing before this Panel will be convened as soon as reasonably practical for the purpose of receiving the parties' submissions with respect to the order or orders which should be issued by the Panel pursuant to s.59.6(1) of the *Act*.

DATED this 6th day of May, 2020.